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CHALENG 2005 Survey: VAMC Asheville, NC - 637

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 126

2. Estimated Number of Veterans who are Chronically Homeless: 44

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 126 (estimated number of homeless veterans in service area) **x chronically homeless rate (35 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	414	25
Transitional Housing Beds	253	20
Permanent Housing Beds	75	75

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Detoxification from substances	Reach out into the community through funding positions to conduct outreach. Position would educate and develop resources. Stand Down to provide detox.
Re-entry services for incarcerated veterans	Identify, accessing of veterans incarcerated and refer to appropriate services. Processing directly to a transitional housing program grant-funded specifically for this population.
Dental care	Discuss with community dental providers on unmet needs. VA to expand dental services. Identify a point of contact person to coordinate referral and access. VA to recognize % based dental benefits based on length of time served.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **28 Non-VA staff Participants: 77.8%**
Homeless/Formerly Homeless: **39.3%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.96	.0%	3.47
Food	4.33	9.0%	3.80
Clothing	3.89	.0%	3.61
Emergency (immediate) shelter	3.96	22.0%	3.33
Halfway house or transitional living facility	3.39	18.0%	3.07
Long-term, permanent housing	3.22	59.0%	2.49
Detoxification from substances	3.38	30.0%	3.41
Treatment for substance abuse	3.77	9.0%	3.55
Services for emotional or psychiatric problems	4.0	14.0%	3.46
Treatment for dual diagnosis	3.8	9.0%	3.30
Family counseling	3.46	5.0%	2.99
Medical services	4.38	.0%	3.78
Women's health care	3.52	5.0%	3.23
Help with medication	4.11	5.0%	3.46
Drop-in center or day program	3.62	4.0%	2.98
AIDS/HIV testing/counseling	3.72	5.0%	3.51
TB testing	3.56	5.0%	3.71
TB treatment	3.42	5.0%	3.57
Hepatitis C testing	3.58	.0%	3.63
Dental care	2.96	27.0%	2.59
Eye care	3.54	5.0%	2.88
Glasses	3.50	.0%	2.88
VA disability/pension	4.04	5.0%	3.40
Welfare payments	3.54	.0%	3.03
SSI/SSD process	3.77	18.0%	3.10
Guardianship (financial)	3.28	.0%	2.85
Help managing money	3.40	5.0%	2.87
Job training	3.77	9.0%	3.02
Help with finding a job or getting employment	3.89	9.0%	3.14
Help getting needed documents or identification	4.19	.0%	3.28
Help with transportation	3.81	9.0%	3.02
Education	3.73	.0%	3.00
Child care	3.25	5.0%	2.45
Legal assistance	3.58	5.0%	2.71
Discharge upgrade	4.00	.0%	3.00
Spiritual	4.33	.0%	3.36
Re-entry services for incarcerated veterans	3.52	14.0%	2.72
Elder Healthcare	3.64	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	3.29
Co-location of Services - Services from the VA and your agency provided in one location.	2.52
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.24
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.62
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	2.10
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	2.00
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.14
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.86
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.45
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.71
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.81
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.43

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	4.14
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.90

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CHALENG 2005 Survey: VAMC Beckley, WV - 517

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 10

2. Estimated Number of Veterans who are Chronically Homeless: 6

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 10 (estimated number of homeless veterans in service area) **x chronically homeless rate (63 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	50	0
Transitional Housing Beds	50	0
Permanent Housing Beds	50	0

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 9

3. CHALENG Point of Contact Action Plan for FY 2005

Immediate shelter	Continue coordination with current emergency shelters. Community education re: services via quarterly community homeless networking meetings.
Treatment for substance abuse	Continue coordination with current community and VA agencies providing service. Community education/awareness through agency networking during quarterly meetings.
Long-term, permanent housing	Learn and identify through quarterly networking meeting agencies interested in providing permanent housing. Offer grant information for agencies to pursue.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **10** **Non-VA staff Participants: 80.0%**
Homeless/Formerly Homeless: **.0%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.00	.0%	3.47
Food	3.22	.0%	3.80
Clothing	3.22	.0%	3.61
Emergency (immediate) shelter	3.44	33.0%	3.33
Halfway house or transitional living facility	2.88	.0%	3.07
Long-term, permanent housing	2.38	33.0%	2.49
Detoxification from substances	2.88	11.0%	3.41
Treatment for substance abuse	3.38	44.0%	3.55
Services for emotional or psychiatric problems	3.3	11.0%	3.46
Treatment for dual diagnosis	3.1	.0%	3.30
Family counseling	3.00	.0%	2.99
Medical services	3.50	22.0%	3.78
Women's health care	3.00	11.0%	3.23
Help with medication	3.00	.0%	3.46
Drop-in center or day program	2.71	.0%	2.98
AIDS/HIV testing/counseling	3.00	11.0%	3.51
TB testing	3.25	11.0%	3.71
TB treatment	3.25	11.0%	3.57
Hepatitis C testing	3.25	.0%	3.63
Dental care	2.63	11.0%	2.59
Eye care	2.88	.0%	2.88
Glasses	2.88	.0%	2.88
VA disability/pension	3.43	11.0%	3.40
Welfare payments	2.86	.0%	3.03
SSI/SSD process	2.88	11.0%	3.10
Guardianship (financial)	2.75	11.0%	2.85
Help managing money	2.50	.0%	2.87
Job training	2.38	.0%	3.02
Help with finding a job or getting employment	2.75	.0%	3.14
Help getting needed documents or identification	3.13	.0%	3.28
Help with transportation	2.75	22.0%	3.02
Education	2.75	.0%	3.00
Child care	2.13	.0%	2.45
Legal assistance	2.13	.0%	2.71
Discharge upgrade	3.13	.0%	3.00
Spiritual	3.00	.0%	3.36
Re-entry services for incarcerated veterans	2.13	11.0%	2.72
Elder Healthcare	2.75	11.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	1.71
Co-location of Services - Services from the VA and your agency provided in one location.	1.00
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.29
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.00
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.00
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.33
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.00
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.00
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.00
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.00
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.00
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.00

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	2.88
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	2.50

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CHALENG 2005 Survey: VAMC Durham, NC - 558

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 325

2. Estimated Number of Veterans who are Chronically Homeless: 137

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 325 (estimated number of homeless veterans in service area) **x chronically homeless rate (42 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	90	10
Transitional Housing Beds	45	5
Permanent Housing Beds	25	0

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 4

3. CHALENG Point of Contact Action Plan for FY 2005

Transitional living facility or halfway house	As in the past, this needs remains the greatest in the Durham VAMC area. While several private transitional housing programs have opened during the past 12 months, the programs will not provide housing for homeless veterans without financial resources.
Medical Services	Without insurance or income to pay for care, homeless veterans must seek care at their local VA.
Help finding a job or getting employment	With employment and medical insurance, the veteran will be able to transition from homelessness to housing and medical coverage.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **30 Non-VA staff Participants: 89.7%**
Homeless/Formerly Homeless: **36.7%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.15	3.0%	3.47
Food	3.93	.0%	3.80
Clothing	3.78	3.0%	3.61
Emergency (immediate) shelter	3.73	17.0%	3.33
Halfway house or transitional living facility	2.43	62.0%	3.07
Long-term, permanent housing	2.29	48.0%	2.49
Detoxification from substances	3.88	.0%	3.41
Treatment for substance abuse	3.63	34.0%	3.55
Services for emotional or psychiatric problems	3.7	3.0%	3.46
Treatment for dual diagnosis	3.8	7.0%	3.30
Family counseling	2.96	.0%	2.99
Medical services	3.93	21.0%	3.78
Women's health care	3.31	3.0%	3.23
Help with medication	3.62	7.0%	3.46
Drop-in center or day program	1.48	14.0%	2.98
AIDS/HIV testing/counseling	4.11	.0%	3.51
TB testing	4.27	.0%	3.71
TB treatment	4.23	.0%	3.57
Hepatitis C testing	4.30	.0%	3.63
Dental care	1.81	24.0%	2.59
Eye care	2.11	3.0%	2.88
Glasses	2.04	.0%	2.88
VA disability/pension	3.28	3.0%	3.40
Welfare payments	1.79	.0%	3.03
SSI/SSD process	3.29	.0%	3.10
Guardianship (financial)	2.96	.0%	2.85
Help managing money	2.93	.0%	2.87
Job training	2.64	10.0%	3.02
Help with finding a job or getting employment	3.04	21.0%	3.14
Help getting needed documents or identification	3.31	.0%	3.28
Help with transportation	3.30	.0%	3.02
Education	2.86	.0%	3.00
Child care	2.10	3.0%	2.45
Legal assistance	3.07	3.0%	2.71
Discharge upgrade	3.41	.0%	3.00
Spiritual	4.04	.0%	3.36
Re-entry services for incarcerated veterans	2.50	3.0%	2.72
Elder Healthcare	3.52	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.74
Co-location of Services - Services from the VA and your agency provided in one location.	1.84
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.79
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.11
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.42
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.42
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.53
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.56
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.42
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.26
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.21
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.42

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.30
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.36

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CHALENG 2005 Survey: VAMC Fayetteville, NC - 565

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 150

2. Estimated Number of Veterans who are Chronically Homeless: 44

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 150 (estimated number of homeless veterans in service area) **x chronically homeless rate (29 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	110	10
Transitional Housing Beds	33	10
Permanent Housing Beds	20	5

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 10

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Continue to discuss at community meeting and encourage local shelter providers to apply for VA Grant and Per Diem
Immediate shelter	Seek and encourage greater participation from local community.
Transitional living facility or halfway house	Seek community help to increase number of area facilities.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **29** **Non-VA staff Participants: 100.0%**
Homeless/Formerly Homeless: **3.4%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.37	.0%	3.47
Food	3.96	10.0%	3.80
Clothing	3.78	.0%	3.61
Emergency (immediate) shelter	2.85	45.0%	3.33
Halfway house or transitional living facility	2.89	34.0%	3.07
Long-term, permanent housing	2.46	48.0%	2.49
Detoxification from substances	2.96	10.0%	3.41
Treatment for substance abuse	3.12	10.0%	3.55
Services for emotional or psychiatric problems	3.0	7.0%	3.46
Treatment for dual diagnosis	2.8	7.0%	3.30
Family counseling	3.00	3.0%	2.99
Medical services	3.26	10.0%	3.78
Women's health care	3.07	3.0%	3.23
Help with medication	3.04	10.0%	3.46
Drop-in center or day program	2.93	10.0%	2.98
AIDS/HIV testing/counseling	3.37	3.0%	3.51
TB testing	3.30	.0%	3.71
TB treatment	3.15	.0%	3.57
Hepatitis C testing	3.30	.0%	3.63
Dental care	2.26	7.0%	2.59
Eye care	2.48	.0%	2.88
Glasses	2.67	3.0%	2.88
VA disability/pension	3.22	7.0%	3.40
Welfare payments	3.26	3.0%	3.03
SSI/SSD process	3.46	3.0%	3.10
Guardianship (financial)	2.69	3.0%	2.85
Help managing money	2.70	3.0%	2.87
Job training	3.15	3.0%	3.02
Help with finding a job or getting employment	3.44	3.0%	3.14
Help getting needed documents or identification	3.33	3.0%	3.28
Help with transportation	2.56	17.0%	3.02
Education	3.11	7.0%	3.00
Child care	2.50	3.0%	2.45
Legal assistance	2.56	.0%	2.71
Discharge upgrade	2.74	.0%	3.00
Spiritual	3.78	3.0%	3.36
Re-entry services for incarcerated veterans	2.78	7.0%	2.72
Elder Healthcare	2.81	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.69
Co-location of Services - Services from the VA and your agency provided in one location.	1.54
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.63
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	1.74
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.56
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.46
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.65
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.08
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.92
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.50
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.54
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.69

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.36
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.12

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2005 Survey: VAMC Hampton, VA - 590

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 446

2. Estimated Number of Veterans who are Chronically Homeless: 156

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 446 (estimated number of homeless veterans in service area) **x chronically homeless rate (35 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	250	50
Transitional Housing Beds	200	40
Permanent Housing Beds	50	50

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 3

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Support new 40-bed SRO being built in Norfolk and support plans being developed for another 40-bed SRO in Virginia Beach. Attempt to recruit an agency to develop Housing First model in Norfolk.
Transitional living facility or halfway house	Week to recruit a nonprofit to apply for GPD funding.
Immediate shelter	Locate/enlist winter shelter provider to go year-round.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **22 Non-VA staff Participants: 42.9%**
Homeless/Formerly Homeless: **31.8%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.73	.0%	3.47
Food	3.71	10.0%	3.80
Clothing	3.33	5.0%	3.61
Emergency (immediate) shelter	2.91	33.0%	3.33
Halfway house or transitional living facility	3.19	29.0%	3.07
Long-term, permanent housing	2.18	52.0%	2.49
Detoxification from substances	3.68	5.0%	3.41
Treatment for substance abuse	3.91	10.0%	3.55
Services for emotional or psychiatric problems	4.0	19.0%	3.46
Treatment for dual diagnosis	3.7	5.0%	3.30
Family counseling	3.00	5.0%	2.99
Medical services	4.05	14.0%	3.78
Women's health care	3.53	.0%	3.23
Help with medication	4.14	.0%	3.46
Drop-in center or day program	2.79	10.0%	2.98
AIDS/HIV testing/counseling	3.80	.0%	3.51
TB testing	3.65	.0%	3.71
TB treatment	3.68	.0%	3.57
Hepatitis C testing	3.75	.0%	3.63
Dental care	2.14	18.0%	2.59
Eye care	2.77	.0%	2.88
Glasses	2.57	10.0%	2.88
VA disability/pension	3.68	14.0%	3.40
Welfare payments	2.95	.0%	3.03
SSI/SSD process	3.25	10.0%	3.10
Guardianship (financial)	3.11	.0%	2.85
Help managing money	2.81	14.0%	2.87
Job training	2.90	14.0%	3.02
Help with finding a job or getting employment	3.09	5.0%	3.14
Help getting needed documents or identification	3.27	.0%	3.28
Help with transportation	3.29	.0%	3.02
Education	2.95	.0%	3.00
Child care	1.89	10.0%	2.45
Legal assistance	2.55	5.0%	2.71
Discharge upgrade	3.06	.0%	3.00
Spiritual	3.48	5.0%	3.36
Re-entry services for incarcerated veterans	2.89	10.0%	2.72
Elder Healthcare	3.42	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	3.11
Co-location of Services - Services from the VA and your agency provided in one location.	2.67
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.78
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.56
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.25
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.50
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.38
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.44
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.11
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.00
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.43
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.29

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	4.22
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	4.00

Prepared by John Nakashima, Ph.D., MSW
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CHALENG 2005 Survey: VAMC Richmond, VA - 652

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 315

2. Estimated Number of Veterans who are Chronically Homeless: 69

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 315 (estimated number of homeless veterans in service area) **x chronically homeless rate (22 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	36	25
Transitional Housing Beds	46	25
Permanent Housing Beds	10	25

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 1

3. CHALENG Point of Contact Action Plan for FY 2005

Immediate shelter	In 2005 our existing Grant and Per Diem partners were approved for grant expansion. This will serve more veterans.
Treatment for dual diagnosis	Informal agreement with Safe Haven. This is a facility that treats dual diagnosis clients.
Help with Transportation.	Work with Disabled American Veterans. Order bus tickets for city usage. Outreach providers also offer transportation.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **3** **Non-VA staff Participants: 0%**
Homeless/Formerly Homeless: **0%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	2.67	0%	3.47
Food	3.67	0%	3.80
Clothing	3.00	0%	3.61
Emergency (immediate) shelter	3.00	100%	3.33
Halfway house or transitional living facility	4.00	33.3%	3.07
Long-term, permanent housing	4.00	0%	2.49
Detoxification from substances	3.00	0%	3.41
Treatment for substance abuse	4.33	0%	3.55
Services for emotional or psychiatric problems	4.00	0%	3.46
Treatment for dual diagnosis	4.00	0%	3.30
Family counseling	4.00	0%	2.99
Medical services	4.00	0%	3.78
Women's health care	4.00	0%	3.23
Help with medication	4.00	0%	3.46
Drop-in center or day program	3.00	0%	2.98
AIDS/HIV testing/counseling	3.67	0%	3.51
TB testing	3.00	0%	3.71
TB treatment	4.00	0%	3.57
Hepatitis C testing	3.33	0%	3.63
Dental care	3.00	33%	2.59
Eye care	3.00	0%	2.88
Glasses	3.00	0%	2.88
VA disability/pension	3.67	0%	3.40
Welfare payments	2.50	0%	3.03
SSI/SSD process	2.33	0%	3.10
Guardianship (financial)	2.00	33%	2.85
Help managing money	2.67	0%	2.87
Job training	3.00	0%	3.02
Help with finding a job or getting employment	3.00	0%	3.14
Help getting needed documents or identification	2.67	0%	3.28
Help with transportation	2.67	0%	3.02
Education	2.33	0%	3.00
Child care	2.00	0%	2.45
Legal assistance	2.00	0%	2.71
Discharge upgrade	3.33	0%	3.00
Spiritual	3.00	0%	3.36
Re-entry services for incarcerated veterans	2.33	66%	2.72
Elder Healthcare	3.00	0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	
Co-location of Services - Services from the VA and your agency provided in one location.	
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2005 Survey: VAMC Salem, VA - 658

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 150

2. Estimated Number of Veterans who are Chronically Homeless: 45

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 150 (estimated number of homeless veterans in service area) **x chronically homeless rate (30 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	237	0
Transitional Housing Beds	30	50
Permanent Housing Beds	50	50

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 3

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Continue to discuss and seek solutions during local homeless task force meeting and Continuum of Care meetings.
Dental care	Continue to seek local, state, federal, and private agency assistance.
Help getting needed documents or identification	This is a new problem. Working with community to obtain funds to help the homeless gain access to funds to purchase copy of birth certificates.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **37** **Non-VA staff Participants: 75.7%**
Homeless/Formerly Homeless: **16.2%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.86	.0%	3.47
Food	4.40	12.0%	3.80
Clothing	4.00	9.0%	3.61
Emergency (immediate) shelter	4.08	6.0%	3.33
Halfway house or transitional living facility	3.16	15.0%	3.07
Long-term, permanent housing	2.62	44.0%	2.49
Detoxification from substances	3.83	.0%	3.41
Treatment for substance abuse	3.95	6.0%	3.55
Services for emotional or psychiatric problems	3.7	11.0%	3.46
Treatment for dual diagnosis	3.5	3.0%	3.30
Family counseling	2.81	.0%	2.99
Medical services	4.24	6.0%	3.78
Women's health care	3.51	6.0%	3.23
Help with medication	3.49	.0%	3.46
Drop-in center or day program	3.32	.0%	2.98
AIDS/HIV testing/counseling	3.43	.0%	3.51
TB testing	3.27	.0%	3.71
TB treatment	3.24	.0%	3.57
Hepatitis C testing	3.41	6.0%	3.63
Dental care	2.41	53.0%	2.59
Eye care	2.86	12.0%	2.88
Glasses	2.80	6.0%	2.88
VA disability/pension	3.91	.0%	3.40
Welfare payments	3.43	3.0%	3.03
SSI/SSD process	3.43	6.0%	3.10
Guardianship (financial)	2.86	6.0%	2.85
Help managing money	2.97	22.0%	2.87
Job training	3.24	12.0%	3.02
Help with finding a job or getting employment	3.57	11.0%	3.14
Help getting needed documents or identification	3.23	29.0%	3.28
Help with transportation	3.22	6.0%	3.02
Education	3.00	6.0%	3.00
Child care	2.23	6.0%	2.45
Legal assistance	2.86	.0%	2.71
Discharge upgrade	3.26	.0%	3.00
Spiritual	3.94	6.0%	3.36
Re-entry services for incarcerated veterans	3.00	6.0%	2.72
Elder Healthcare	3.32	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.77
Co-location of Services - Services from the VA and your agency provided in one location.	2.62
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.85
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.85
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.54
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.23
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.38
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.46
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.00
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.54
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.38
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.31

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	4.22
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	4.23

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2005 Survey: VAMC Salisbury, NC - 659

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 1000

2. Estimated Number of Veterans who are Chronically Homeless: 360

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 1000 (estimated number of homeless veterans in service area) **x chronically homeless rate (36 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	1052	30
Transitional Housing Beds	350	0
Permanent Housing Beds	300	500

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Elder Healthcare	Want agreement for hospice palliative care.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **31** **Non-VA staff Participants: 71.0%**
Homeless/Formerly Homeless: **12.9%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.57	4.0%	3.47
Food	3.63	.0%	3.80
Clothing	3.53	4.0%	3.61
Emergency (immediate) shelter	3.55	14.0%	3.33
Halfway house or transitional living facility	3.39	14.0%	3.07
Long-term, permanent housing	2.31	45.0%	2.49
Detoxification from substances	3.38	9.0%	3.41
Treatment for substance abuse	3.35	27.0%	3.55
Services for emotional or psychiatric problems	3.3	14.0%	3.46
Treatment for dual diagnosis	3.2	27.0%	3.30
Family counseling	2.76	.0%	2.99
Medical services	3.67	14.0%	3.78
Women's health care	3.04	5.0%	3.23
Help with medication	3.37	9.0%	3.46
Drop-in center or day program	2.32	.0%	2.98
AIDS/HIV testing/counseling	3.37	.0%	3.51
TB testing	3.50	.0%	3.71
TB treatment	3.43	.0%	3.57
Hepatitis C testing	3.40	.0%	3.63
Dental care	2.27	32.0%	2.59
Eye care	2.53	5.0%	2.88
Glasses	2.57	4.0%	2.88
VA disability/pension	3.20	14.0%	3.40
Welfare payments	2.70	.0%	3.03
SSI/SSD process	3.00	4.0%	3.10
Guardianship (financial)	2.80	.0%	2.85
Help managing money	2.83	.0%	2.87
Job training	2.67	13.0%	3.02
Help with finding a job or getting employment	2.80	9.0%	3.14
Help getting needed documents or identification	3.29	4.0%	3.28
Help with transportation	2.68	27.0%	3.02
Education	2.83	.0%	3.00
Child care	2.20	.0%	2.45
Legal assistance	2.63	9.0%	2.71
Discharge upgrade	3.00	.0%	3.00
Spiritual	3.07	.0%	3.36
Re-entry services for incarcerated veterans	2.57	4.0%	2.72
Elder Healthcare	2.84	14.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.62
Co-location of Services - Services from the VA and your agency provided in one location.	1.62
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.19
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.45
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.70
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.80
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.35
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.25
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.11
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.45
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.47
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.85

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.32
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.64